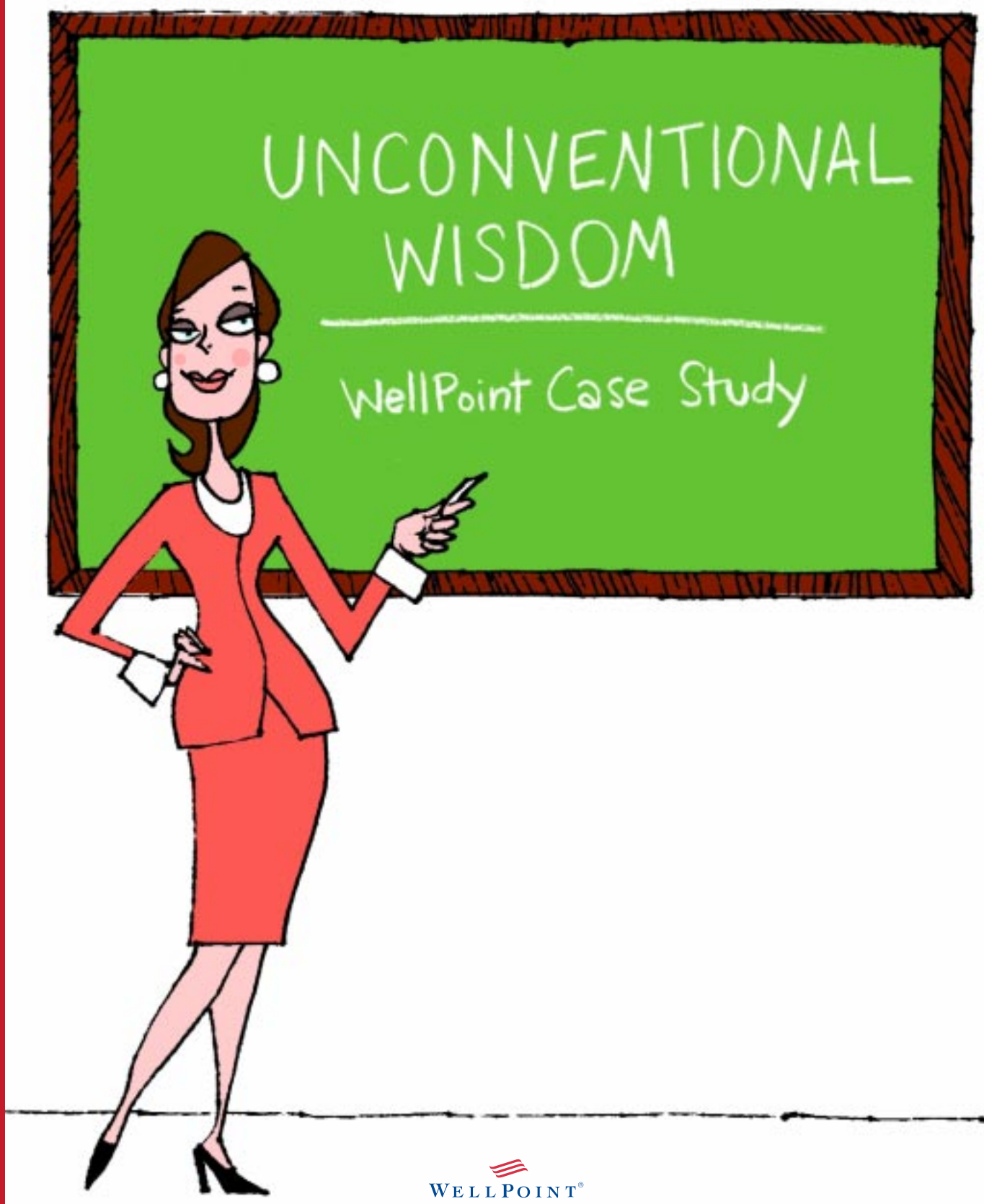


WELLPOINT®

ABOUT THIS REPORT

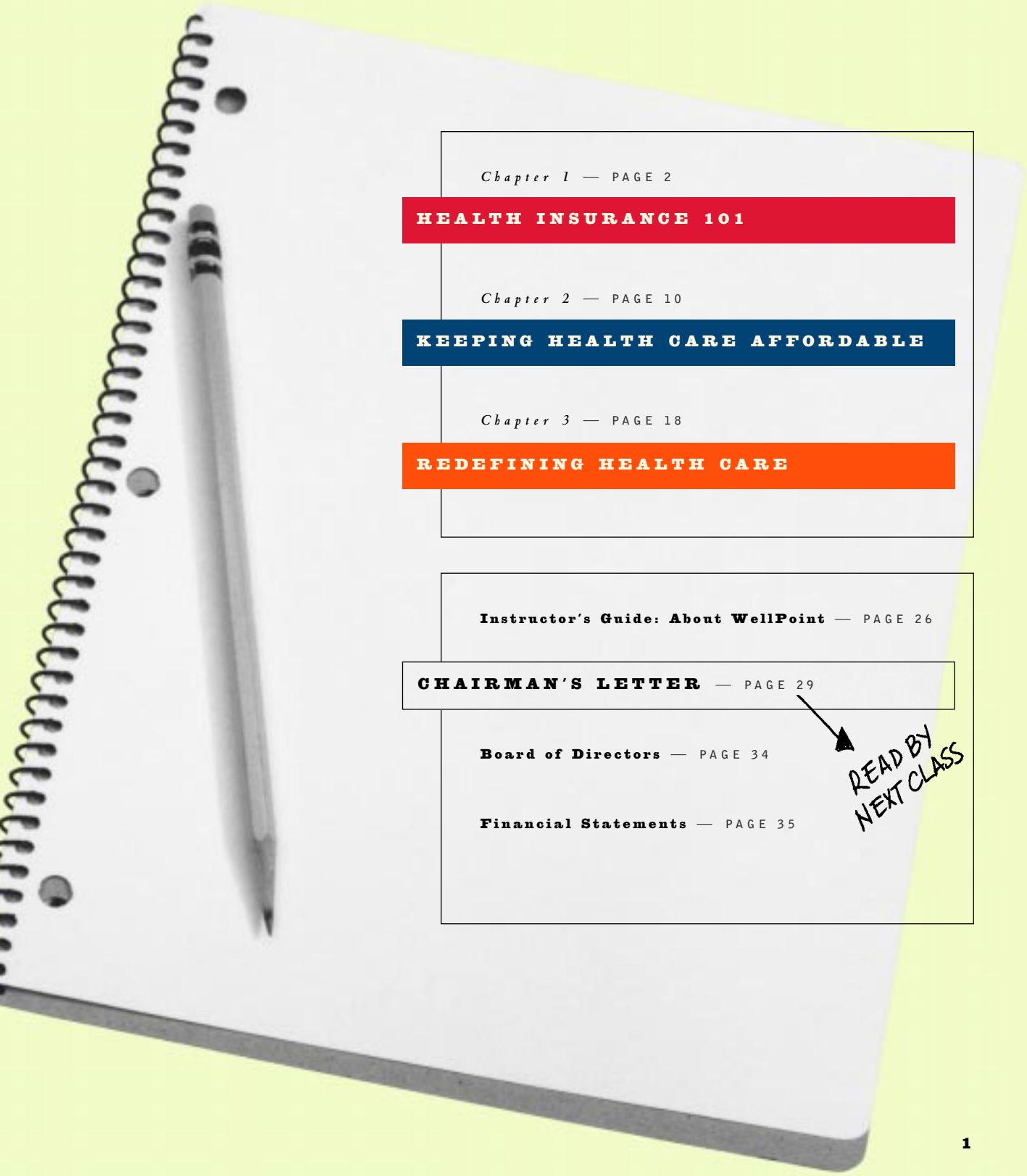
WellPoint's 2000 Annual Report uses education as a vehicle to encourage consumers to explore and understand the role of a health insurance company.

As one of the largest components of the U.S. economy, health care represents 14 percent of the gross domestic product. Health care spending is driven not only by an aging population, but also by the desire of consumers to maintain a healthy lifestyle and their willingness to pay for it. Consumers want and need more information, resources and input regarding their health care needs.

This report addresses key industry issues and highlights the steps WellPoint is taking to meet the needs of its members. By providing consumers with tools and information they need to make informed health care decisions, WellPoint is working to play an integral role in improving the quality of health care.

CLASS MEETS
TUES & THURS
LECTURE HALL A

TABLE OF CONTENTS



Chapter 1 — PAGE 2

HEALTH INSURANCE 101

Chapter 2 — PAGE 10

KEEPING HEALTH CARE AFFORDABLE

Chapter 3 — PAGE 18

REDEFINING HEALTH CARE

Instructor's Guide: About WellPoint — PAGE 26

CHAIRMAN'S LETTER — PAGE 29

Board of Directors — PAGE 34

Financial Statements — PAGE 35

READ BY NEXT CLASS

Chapter 1

HEALTH INSURANCE 101

CHAPTER OVERVIEW

The need for major medical treatment over the course of a lifetime is often unpredictable. Health insurance helps protect an individual or family from the financial burden associated with the high cost of medical care.

THE INDUSTRY

In its simplest form, health insurance is similar to auto or home insurance. In return for a premium, an insurance company offers coverage for a specific set of incurred expenses. Some customers will have very large expenses that must be paid for, while many others will incur small or no expenses. A successful insurance company will design products that have attractive benefits and premiums that help cover expenses for all of its customers.

Health insurance also differs in many ways from other forms of insurance. For example, many Americans pay only a portion of their premium cost for health benefits — their employers pay the rest. In addition, consumers are insulated from the full retail cost of health care — their insurance company has negotiated significant discounts for services provided by network physicians, hospitals and other clinicians. And consumers today expect more from health insurance

— they want coverage for preventive services, treatments to improve their quality of life and more information and assistance about how best to use the health care system.

The health insurance industry historically focused on paying claims; that is, reimbursing doctors and hospitals for "usual and customary" charges for the services they provided. However, health costs rapidly escalated in the 1980s, forcing the industry to develop new approaches to control costs. Network-based products were developed, some physician groups were prepaid a fixed fee for a given population of potential patients, and the notion of a primary care physician — one who coordinates access to care — was introduced.

Americans gradually became familiar with several product acronyms related to their experience with health care. The two primary product categories are preferred provider organization (PPO) and health maintenance organization (HMO).

WELLPOINT'S HYBRID PRODUCTS OFFER THE BEST OF BOTH

PPOs allow members to select primary care and specialist physicians from a broad network. A member wanting to see a specialist, such as a dermatologist, chooses a doctor within the network, with services paid for according to the benefit coverages in the member's health plan.

HMOs typically offer a comprehensive array of benefits but with a primary care physician who coordinates and monitors a member's health care needs. If an HMO member wants to see a dermatologist, then that member's primary care physician decides whether the patient should be referred to the network specialist to receive benefits under the plan.

While HMOs and PPOs helped to control the escalating costs of the 1980s and 1990s, consumers reacted negatively to many of the changes. The hassles and restrictions of the HMO, particularly for members with minor health care needs, caused a backlash. In addition, the industry as a whole was not creative in designing products to address demographic changes resulting from the aging of the Baby Boomers and advancing medical technology.

The "one size fits all" approach doesn't cut it in an industry that must be responsive to the changing needs of consumers.

One size does not fit all...

...WellPoint tailors products to meet customer needs.

AN ORGANIZATION DESIGNED AROUND THE CUSTOMER

Employer groups of different sizes have widely varying needs, as do individual purchasers and seniors. A start-up company with eight employees may want a choice of low-priced products to help keep costs under control. A large company with 3,500 employees may want more comprehensive benefits to attract and retain job candidates and help with the open enrollment process. A self-employed individual may be looking for an affordable product with catastrophic coverage and two annual physician visits.

WellPoint has long recognized that one size does not fit all. The Company has challenged conventional wisdom that dictates a company must organize by product or function. In an effort to better serve customers, WellPoint is organized by customer segment. Internal divisions apply creativity and appropriate resources in meeting the unique needs of customers in a distinct market segment.

WellPoint puts a great deal of effort into understanding the consumer in a specific market segment. Decisions on new product launches and expanded services are based on extensive data gathering and market research. The Company conducts focus groups, studies consumer buying patterns, interviews brokers, agents and consultants, and uses pilot programs to test customer satisfaction.

The result — WellPoint offers choice-based products that consumers and employers want.

CUSTOMER GROUP	SIZE
INDIVIDUAL	1
SENIOR	1
SMALL GROUP	2-50
KEY ACCOUNTS	51-250
MAJOR ACCOUNTS	251-2000
SPECIAL ACCOUNTS	2001+

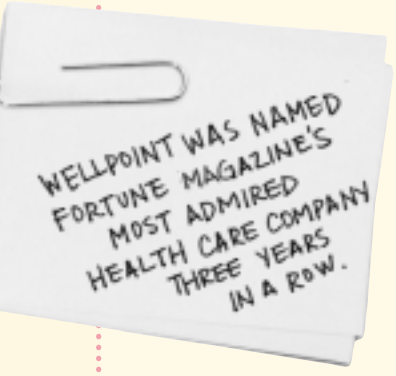
THE WELLPOINT WAY

WellPoint's business process has helped the Company achieve consistent financial results, which is important to both customers and stockholders. The process encourages innovation and creativity in meeting customer needs. It also helps WellPoint maintain control of key steps in managing a very complex business.

The process begins with developing and managing networks of quality health care professionals such as physicians, hospitals and other health care clinicians. As these networks evolve, innovative products are created. Each plan must be priced right, with cost trends, the price sensitivity of customers, and the competitive landscape taken into consideration. After products are priced, they must be sold profitably.

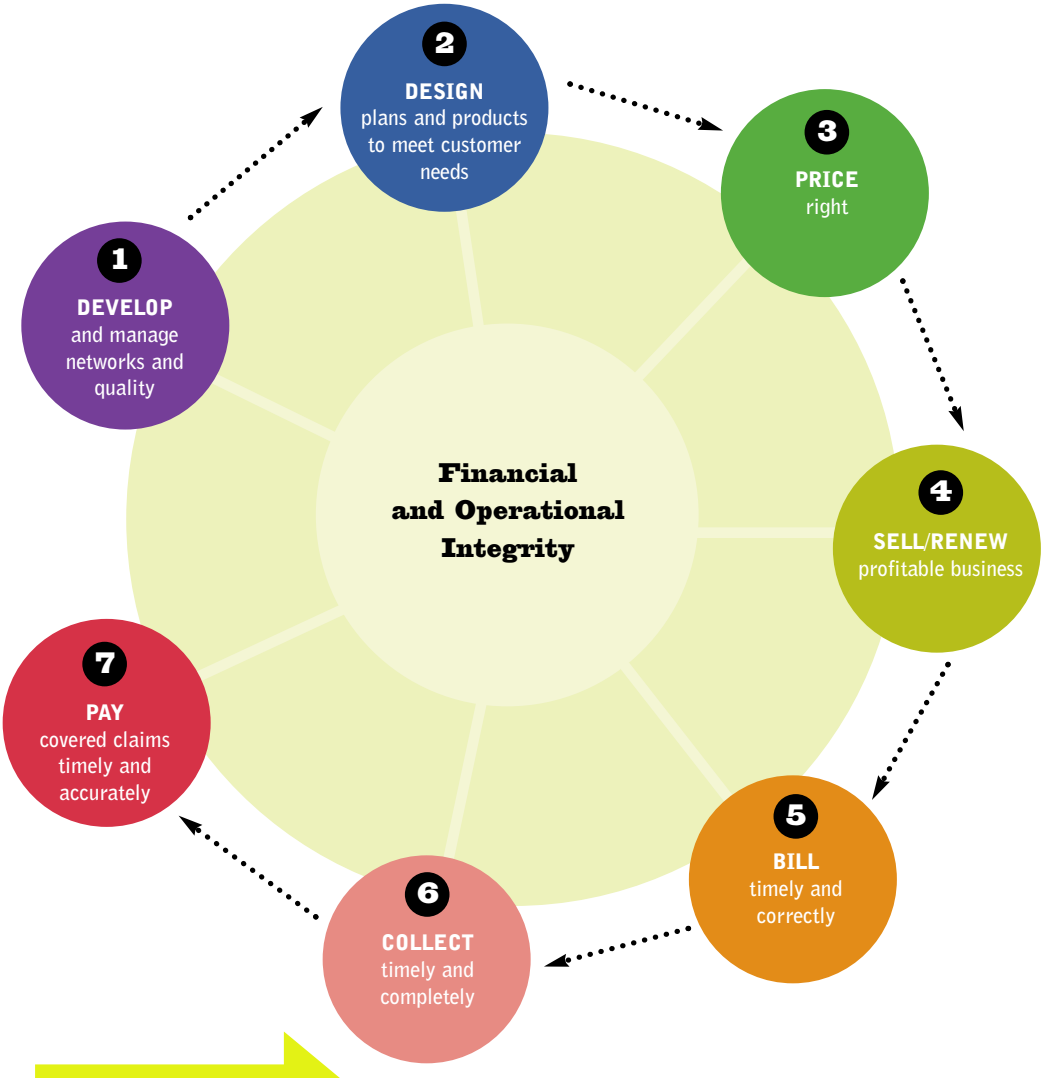
Administrative functions of the business process are just as important as developing and managing networks, and designing and selling a broad array of choice-based products. Because premiums are collected before actual services are rendered, WellPoint focuses on billing customers and paying covered claims in a timely and accurate manner.

WellPoint's focus on operations is one of the reasons why the Company has been successful. Each step of the business process is conducted around a core of financial and operational integrity. Strong financial performance is a key element of providing health security to customers who depend on WellPoint to finance their health care.



THE WELLPOINT WAY

AN EFFECTIVE BUSINESS PROCESS



Increased Satisfaction

- ✓ MEMBERS
- ✓ EMPLOYERS
- ✓ ASSOCIATES
- ✓ HEALTH CARE PROFESSIONALS
- ✓ DISTRIBUTION CHANNELS
- ✓ STOCKHOLDERS

CASE STUDY

FAMILY ELECT: GIVING FAMILIES GREATER CONTROL

A family with four automobiles and four drivers could conceivably have different car insurance coverage for each vehicle, obtaining the best value for their insurance dollar. However, when selecting a health plan, families that buy their own health insurance are often forced to choose one plan that serves the family member with the greatest health care needs. The family often ends up paying for health care benefits above and beyond its requirements.

WellPoint recognized this problem and created a simple but innovative solution — FamilyElect. Why not give families the flexibility to choose different health plans for each family member? FamilyElect allows members to customize a health coverage program that works best for the family overall.

Family members with significant medical needs may select a plan with appropriate coverage levels. Others in the family with minor needs may select plans with lower benefit levels and associated premiums. By not paying for health benefits that aren't needed, a family can actually lower its annual health care costs.

With products like FamilyElect, WellPoint offers each member greater control of their health and financial future.

MOM

I like the choice of open-access.

DAD

A hybrid plan looks good to me.

DAUGHTER

I like the stickers from my pediatrician.

SON

I just need the most basic plan.

DOG

I'm into prevention — how about a flea collar?

CHAPTER REVIEW

KEY WORDS

- WellPoint
- Customization
- Business process
- FamilyElect

INDICATE YES OR NO

	Traditional Health Insurance Company	WellPoint
Organized by customer	No	YES
Uses fact-based approach to product development	NO	YES
Innovative products that meet customer needs	NO	YES

MULTIPLE CHOICE

1. Which product allows members to select primary care and specialist physicians from a broad network?

   A. PPO
   B. HMO
   C. TKO
   D. SOS

2. When it comes to products for consumers, WellPoint believes that:

   A. One size fits all.
   B. One size does not fit all.
   C. The size of an employer doesn't matter.
   D. All of the above.

3. Which of the following statements is true?

   A. WellPoint provides members with a choice of products to meet individual needs.
   B. WellPoint has large networks of physicians from which to choose.
   C. WellPoint offers members greater control of their health and financial future.
   D. They are all true.

Answer key: 1. A 2. B 3. D

Chapter 2

KEEPING HEALTH CARE AFFORDABLE

CHAPTER OVERVIEW

The economic forces driving increases in health care costs are formidable. The challenge for the health insurance industry is to find ways to mitigate these cost pressures.

THE INDUSTRY

There are three primary forces driving health care costs. From a demographic standpoint, the sheer number of Baby Boomers aging has greatly increased the demand for medical services. Medical science and technology are continuing to make great advances — this is good news for the health of society, but it is increasingly difficult to finance these breakthroughs for use by the general population. In addition, consumer expectations about what health insurance should pay for are expanding.

On a more specific level, the cost today of treating various illnesses or obtaining certain medical procedures often surprises people. The potential total physician and other charges for an ear infection can be $400; heart by-pass surgery, $55,000; serious bodily injury from an auto accident, $100,000 or more. Even the most routine in-patient hospital admissions can exceed $15,000.

IN 2010, AMERICANS OVER 65 WILL SPEND AN ESTIMATED $55 BILLION ON PRESCRIPTION DRUGS

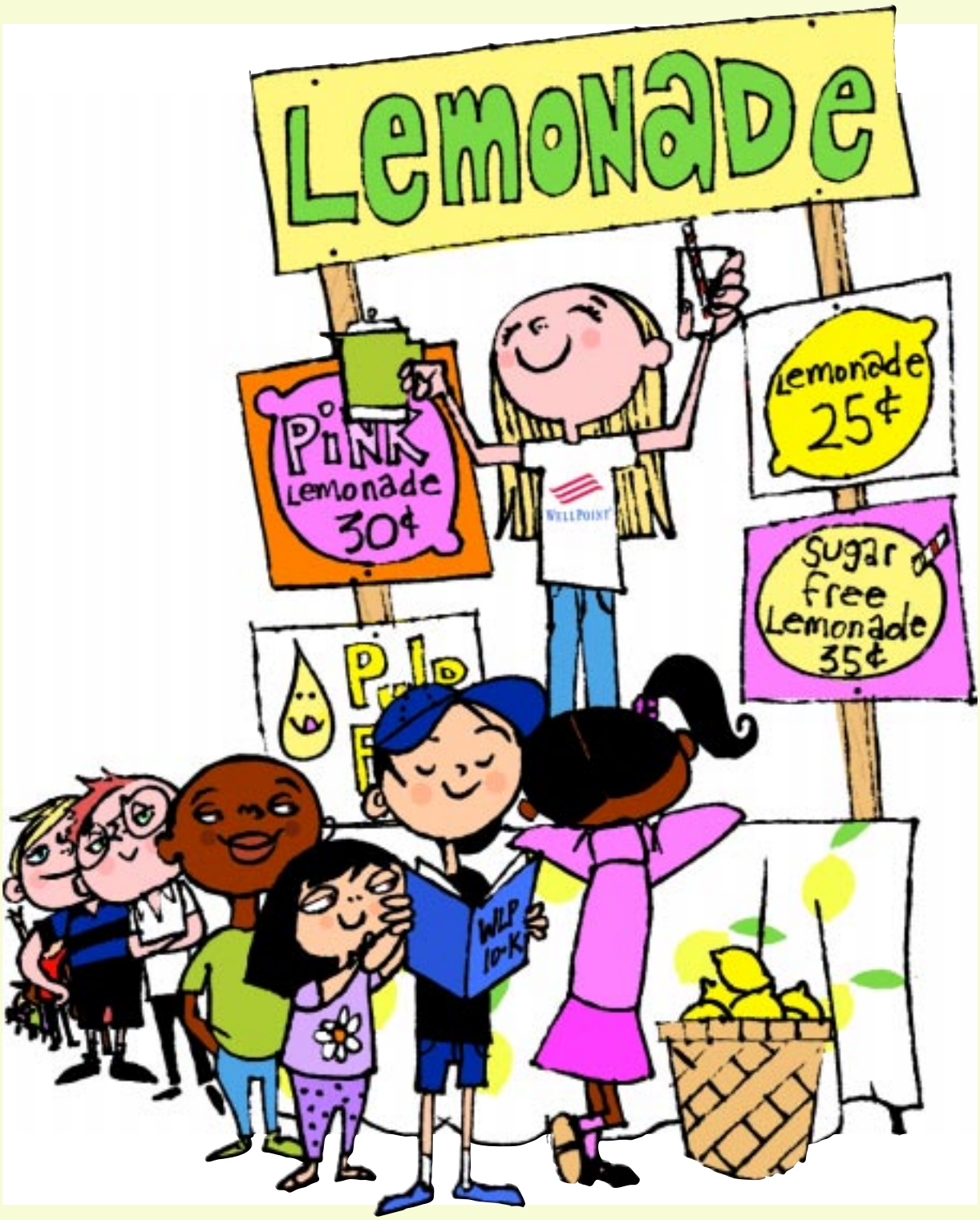
Broad economic trends and increasing health care costs have caused health insurance companies to increase the premiums they charge their customers. As premiums rise, more employers and individuals question the affordability of the insurance. If significant numbers of employer groups and individuals drop out of the health insurance system, premiums for the remaining insured pool must significantly increase since usually the healthiest population leaves first. The challenge for the insurance industry is to find ways to mitigate the increase in premiums, attract currently uninsured businesses and individuals, maintain the existing book of business, and provide rate stability.

Historically, health insurance plans have provided value to customers by negotiating discounted rates for medical services on behalf of plan members and financing most of the cost of major medical care. Unfortunately, consumers have made health care decisions largely insulated from the true cost of care, especially for minor to moderate medical needs. If consumers become more informed about costs and participate more directly in the financing of care, they will become better, more efficient users of health care services.

Better informed consumers make better choices regarding the trade-off between premiums and benefit levels. Relatively healthy consumers who are concerned about premium outlay may select a plan that provides coverage for illness and accidents. Consumers with chronic conditions may select a product with a relatively expensive premium that offers attractive benefits for expected medical needs.

Generally, the health insurance industry needs to increase its understanding of the affordability thresholds of consumers and employers. This knowledge is important for at least two reasons: first, to keep premiums relatively affordable and people insured, and second, to attract more of the uninsured population into the system.

Consumers are sometimes faced with limited, expensive options...



. . . WellPoint offers a variety of affordable products.

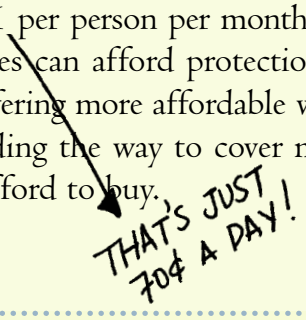
KEEPING INSURANCE AFFORDABLE

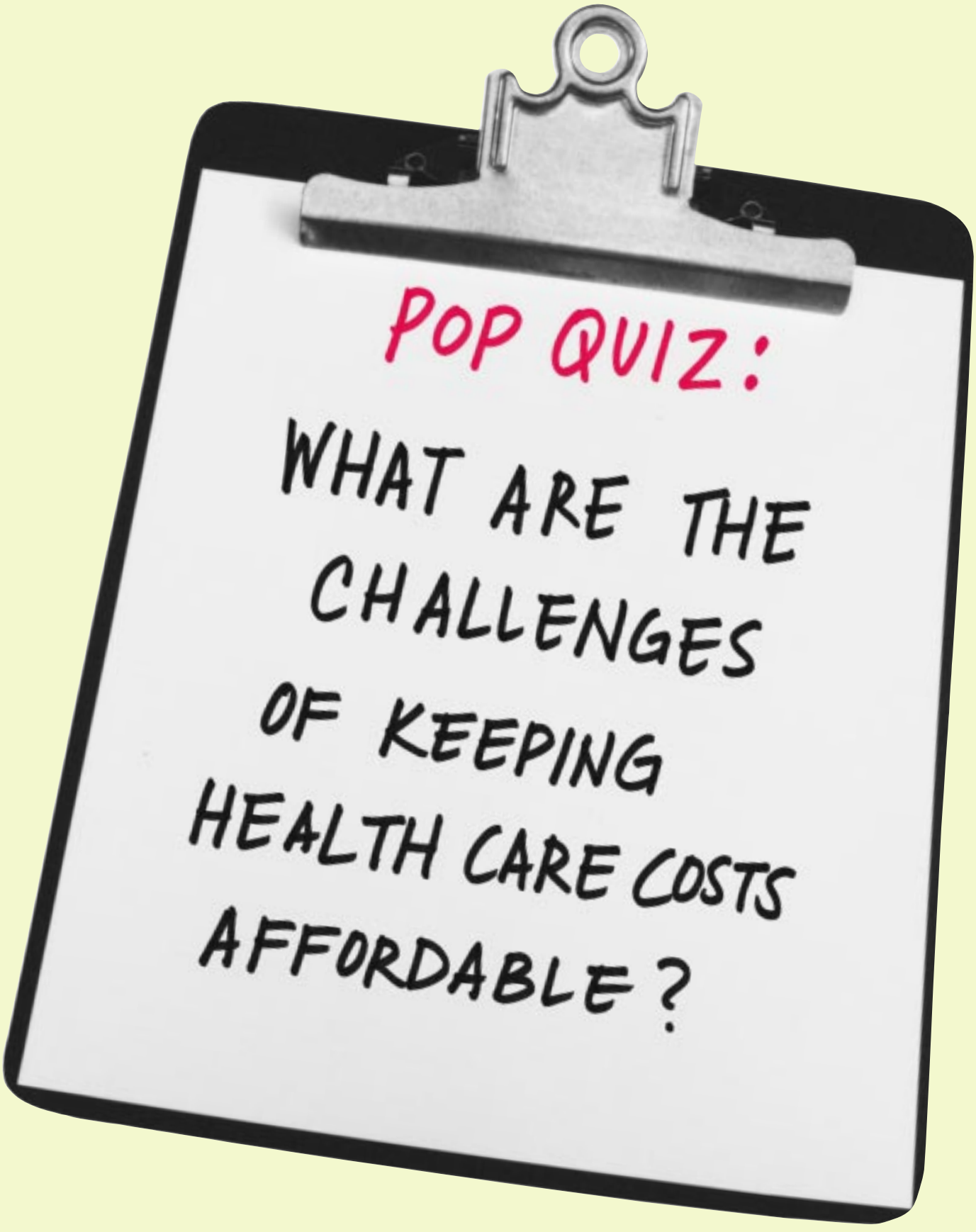
WellPoint has invested significant time and resources in identifying the issues that drive consumer health care purchasing decisions. The Company has substantial experience selling products to individuals and conducts extensive market-based research. As a result, WellPoint has been able to formulate a comprehensive portrait of key product features that motivate health care purchasers. The Company consistently creates new and innovative coverage products based upon consumer expectations, perceptions and price demands.

In the individual and small group market, WellPoint has identified consumers with three distinct attributes: low, medium and high price purchase preferences. Simply stated, a low price purchaser is likely to be uninsured and/or cash constrained. A medium price purchaser may want more extensive health coverage but still remains very price sensitive and faces a variety of competitive coverage options. This group is looking for maximum dollar value in their benefits. In the high price segment, buyers are willing and able to pay for more comprehensive coverage.

On January 1, 2001, the Company introduced PlanScape for individuals in California. PlanScape is based on a strategy of low, medium and high pricing options, combined with a variety of benefit choices and coverages. PlanScape choices range from basic coverage with lower premiums to comprehensive coverage with a greater number of benefit features and moderate premiums. Consumers choose the plan that is right for their health and financial lifestyles.

With market innovations like PlanScape, WellPoint believes it can penetrate more of the uninsured market than ever before. With basic coverage starting as low as $21 per person per month (depending on age and area), both individuals and families can afford protection from unforeseen or catastrophic medical expenses. By offering more affordable ways to obtain better health care coverage, WellPoint is leading the way to cover more people with the programs they both want and can afford to buy.




POP QUIZ:
WHAT ARE THE CHALLENGES OF KEEPING HEALTH CARE COSTS AFFORDABLE?

Name _____

Date _____

Use a #2 pencil. Check all that apply.

QUESTION: What are the challenges of keeping health care costs affordable?

(2 points each)

☑ Rising Consumer Expectations

Today's health care consumer is more educated, resourceful and understands the basics of a market economy. Consumers want information about their health situation and they want to be an active participant in the decision-making process. The public, particularly the Baby Boomers, believes it has the right to all treatments and medicines, no matter what the cost. As the wealthiest generation ever, Baby Boomers will spend more on health care.

☑ Prescription Drugs

Over the last 10 years, total spending on prescription drugs has far outpaced health care expenditures as a whole. The total cost of prescription drugs has been further accelerated by direct-to-consumer advertising. According to the National Institute for Health Care Management, the 25 top-selling drugs promoted directly-to-consumers accounted for nearly 41 percent of the overall increase in drug spending in 1999.

☑ Demographics

By 2010, nearly 75 million Americans will be over the age of 55. As people age, they consume more health care services due to the onset of chronic conditions. Also, as life spans continue to increase, health care spending will rise.

☑ Technology

From neonatal respirators to portable defibrillators, developments in medical technology have revolutionized health care delivery. Advances in medical testing, life support equipment and surgical tools have resulted in early diagnosis, less intrusive procedures, and better outcomes. Technology is also a cost driver since equipment is costly, may face early obsolescence and demands a highly skilled work force.

☑ Access to Information

The Information Age has helped consumers become better informed. In 1999, 70 million Americans searched the web for health related information. However, medical residents at one leading hospital estimate that one out of 10 patients they see is so-called "Internet positive" — meaning they erroneously self-diagnosed an illness from research on the web.

☑ Fraud

Health care fraud costs consumers up to $30 billion a year. This fraud includes unnecessary or inadequate tests as well as phantom billing for health care services that were never rendered.

WELLPOINT'S SPECIAL INVESTIGATION UNIT RECOVERED ALMOST $14 MILLION FROM FRAUDULENT CLAIMS OVER THE PAST THREE YEARS AND ASSISTED LAW ENFORCEMENT AGENCIES IN CRIMINAL INVESTIGATIONS.

CASE STUDY

WELLPOINT TAKES STEPS TO CONTROL RISING DRUG COSTS

WellPoint took an unprecedented step when it became the first health insurance company to petition the Food and Drug Administration (FDA) to move a prescription drug — Claritin — to over-the-counter status.

Claritin, an allergy medication, is safer than many over-the-counter substitutes. It can be purchased in Canada without a prescription for about $15 per standard dosage, versus about $65 plus the cost of a physician visit, in the United States.

WellPoint's petition to the FDA extends beyond the issue of Claritin. As a national publication wrote of the petition, "...(it) could fundamentally alter the way drugs are priced and how quickly consumers get over-the-counter access to new medicines."

CHAPTER REVIEW

KEY WORDS

- Demographics
- Consumerism
- Baby Boomers
- PlanScape

ESSAY QUESTION

Please use black ink. You have 15 minutes to complete your answer.

Q: With heightened consumer expectations, has shyness become an insurable condition?

MULTIPLE CHOICE

1. The best way to keep health care affordable is to:

   A. Create new products that meet customer needs.
   B. Work together with physicians toward achieving better outcomes of health care services.
   C. Provide assistance to members with chronic conditions.
   D. All of the above.

2. As Baby Boomers age, they will:

   A. Consume more health care services.
   B. Demand more quality of life drugs.
   C. Take steps to live longer.
   D. All of the above.

3. In general, how fast are pharmaceutical costs rising?

   A. Below the national inflation rate
   B. At the national inflation rate
   C. Above the national inflation rate
   D. Pharmaceutical costs are not rising

SIGNIFICANTLY ABOVE THE NATIONAL INFLATION RATE!

Answer key: 1. D 2. D 3. C

Chapter 3

REDEFINING HEALTH CARE

CHAPTER OVERVIEW

With the growth of consumerism in medicine, the increasing complexity of the health care system, and variations in the practice of medicine, health insurance companies have an opportunity to provide more effective assistance and service to members.

THE INDUSTRY

Today's health care consumers want more information about their health. In 1999, 70 million Americans searched the Internet for health-related information. Consumers also want to be more involved in the decision-making process about their medical care and want help accessing the health care system. Recent consumer surveys suggest that the majority of respondents want to have a say in treatment decisions and are more likely to stay with a health plan that offers tools to select a doctor of their choice.

The complexity of our health care system is reflected in part by the fact that medical technology continues to advance. New treatments for major diseases and chronic conditions are moving from the experimental stage to use as the accepted standard of care more quickly. New tests and screening procedures are proliferating.

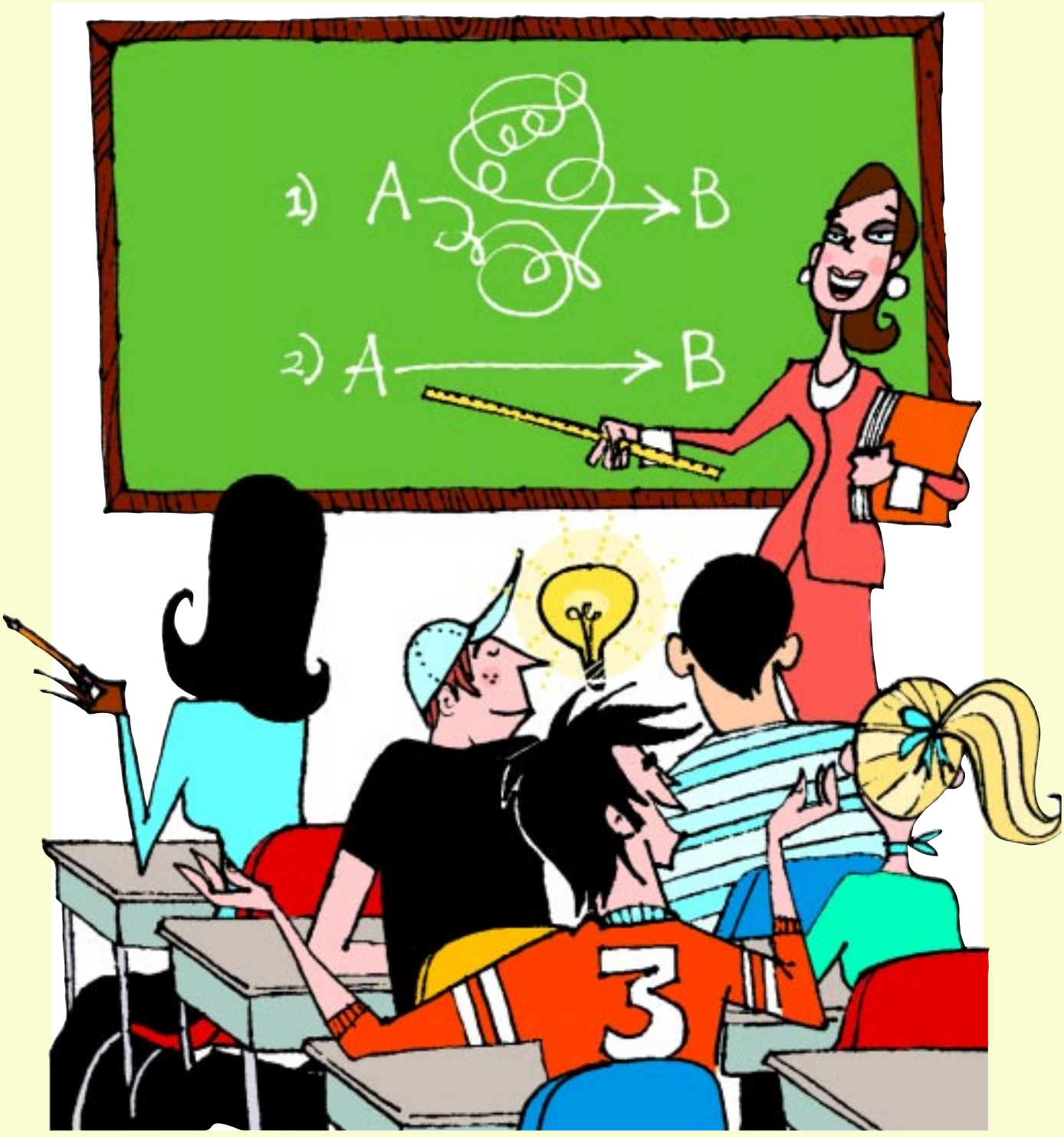
The creation of blockbuster drugs and new pharmaceutical therapies has improved medical outcomes for millions of Americans. Other drugs have enhanced the quality of life, but also have raised issues about who should pay for these pharmaceuticals.

The quality of care in the U.S. is generally the best in the world. However, there are sometimes wide variations in the application of recognized standards of care. Last year, a national publication documented how the frequency of certain surgeries varied as much as seven times depending upon where a patient lives, not on established protocols.

There also are needless gaps in health care knowledge. For example, at least one third of the 16 million Americans estimated to have diabetes are not aware of it. Half of the patients diagnosed with the disease do not manage their condition. As a result, many diabetics unnecessarily suffer from blindness, kidney failure, limb amputations, heart disease, and even death.

The health insurance industry is in a unique position to assist and educate consumers. For example, health plans can help facilitate the use of nationally recognized protocols to help improve the quality and consistency of care.

Understanding complex issues can be difficult...



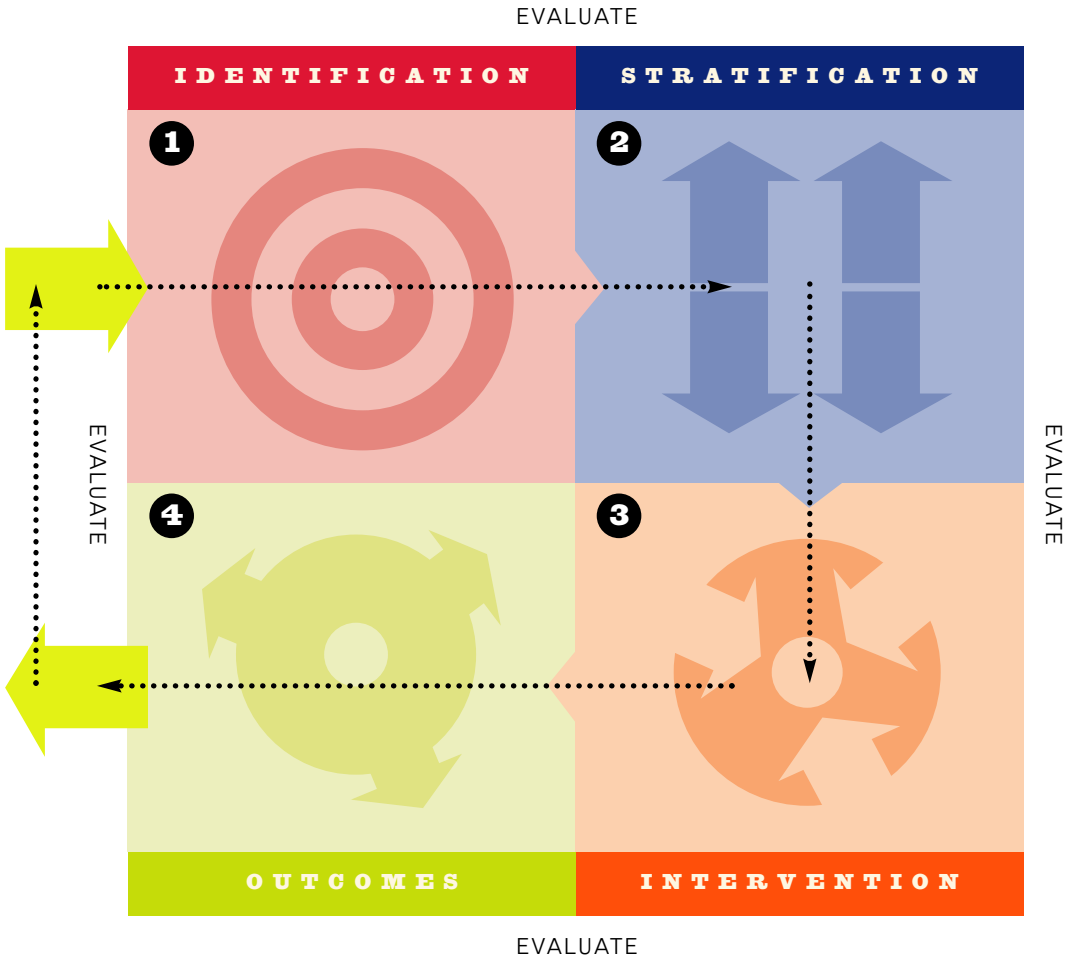
...WellPoint offers assistance in accessing a complex health care system.

WellPoint recognizes that consumers want information regarding their health and to be involved in the decision making process. Consumers also want help in accessing and navigating a very complex health care system.

An example of the assistance WellPoint offers its members is the Company's health management programs. In a given population, 8 percent of the individuals will account for almost 70 percent of total medical costs. The vast majority of this eight percent are individuals suffering from one or multiple chronic conditions such as asthma, diabetes, heart disease, renal disease and depression. These individuals require long term treatment planning and proactive care intervention to manage these chronic diseases and reduce serious medical complications. The key to successful management of these chronic patients is early identification and proactive care management.

WellPoint believes that this approach to health management not only helps produce better outcomes for members, resulting in a better quality of life, but lowers health care costs associated with complications from a given disease. The biggest challenge is to get individuals to take responsibility for their chronic conditions and comply with protocols to manage their diseases. WellPoint tailors its health management programs based on a member's motivation level toward compliance.

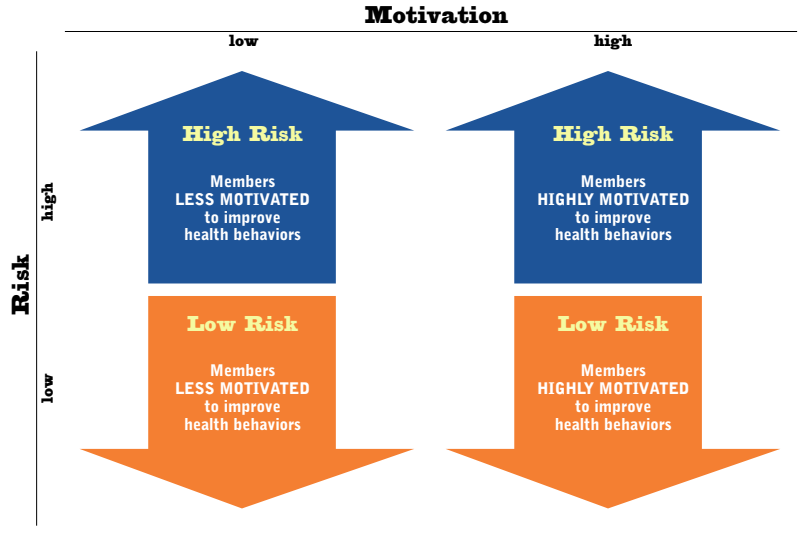
HEALTH MANAGEMENT PROGRAM ELEMENTS



WellPoint's health management program is structured in four parts: identification of a member with a chronic disease; stratification of the population by risk severity and readiness to change; intervention; and outcomes.

HEALTH MANAGEMENT

After a member with a chronic disease has been identified and has agreed to participate in WellPoint's health management program, the severity of the member's disease and readiness to change are considered.



WellPoint's unique intervention model utilizes this information to determine the appropriate level and type of intervention. Case managers, who are registered nurses, contact members who could benefit from the health management program. They assess the member's knowledge of their condition, review the physician's current treatment plan, and discuss circumstances at home or work that could impact the member's health. By working together with the member's physician, case managers work to facilitate best practices in the health management process for the particular condition.

The health management program provides ongoing follow-up by personal case managers and continuous education to help members actively pursue a regimen of beneficial care. As a result, the program is a triple win: a win for the member, a win for the physician, and a win for WellPoint.

CASE STUDY

LOVE YOUR HEART PROGRAM... SWEET SUCCESS

WellPoint's **Love Your Heart Program** is uniquely targeted to assist in improving the overall health of people with heart conditions. Alfred Vanacore's experience with WellPoint provides an example of the positive outcomes members have experienced through the Company's health management programs.

IDENTIFICATION

When Alfred Vanacore, a 62 year old small business owner, completed the survey sent to him from the **Love Your Heart Program**, he confidently responded "no" to the question "Have you ever been told by a physician that you have diabetes?" He was aware that he had a family history of diabetes, and wondered if his excessive thirst and frequent trips to the bathroom were in any way related to the disease. If left untreated, diabetes can have a catastrophic impact on individuals with heart disease. The **Love Your Heart Program** takes a proactive approach in identifying symptoms of this disease.

STRATIFICATION

Shortly after the completion of his survey, Alfred received a telephone call from Lynn Scott, R.N., a **Love Your Heart** nurse. Lynn began by asking routine screening questions for the **Love Your Heart Program** and determined that Alfred had coronary artery disease, hypertension, and hyperlipidemia. Alfred told Lynn that he had, in fact, undergone triple coronary artery bypass surgery in 1992 and had an angioplasty in 1998.

INTERVENTION

Lynn discussed with Alfred the lifestyle modifications he could make to reduce the risk of the progression of his heart disease. As part of his assessment, Lynn inquired if he had any other health problems. His response that he was "thirsty all the time, urinating a lot, and had dry skin" immediately alerted Lynn that a prompt medical assessment was necessary. Since Alfred was displaying classic signs of **diabetes mellitus**, Lynn suggested that he call his physician. The visit resulted in a diagnosis, the first step in helping Alfred gain control of his blood sugar and diabetes.

OUTCOMES

For Alfred, the phone call he received from WellPoint's health management nurse had an immediate impact on his life. The program's interventions motivated him to begin a diet and exercise program to reduce his diabetic symptoms. He believes that this lifestyle change has made a difference in managing his diabetes.

As a small business owner, Alfred has resumed business travel and visits his clients on a regular basis. He now enjoys a more active and fulfilling life.

CHAPTER REVIEW

KEY WORDS

- Health management
- Protocols
- Case manager
- Outcomes

WORD PROBLEM

A train leaves Los Angeles at 12:00 P.M. with 800 passengers on board. The train is going to Atlanta at an average speed of 84 MPH. Another train is leaving Chicago at 10:00 A.M. with 1,200 passengers on board. The train is going to Houston at an average speed of 76 MPH.

Q

Question: **Which health insurance company is best for all 2,000 passengers?**

A

Answer: *Because WellPoint's products are available in California under the Blue Cross of California brand, in Georgia under the Blue Cross and Blue Shield of Georgia brand, and in Illinois and Texas under the UNICARE brand, all the passengers receive the choice, value, quality and innovation that are the trademark of all WellPoint products.*

TRUE OR FALSE

T F 1. **WellPoint's health management program is the coordinated, disease specific approach to patient care which helps promote better outcomes for serious and chronic illnesses and their complications.**

T **F** 2. **All people diagnosed with diabetes effectively manage their condition.**

T F 3. **WellPoint's case managers assess the member's knowledge of his or her condition, review the physician's current treatment plan, and discuss circumstances at work or home that could impact the member's health.**

Answer key: 1. T 2. F 3. T

INSTRUCTOR'S GUIDE

WELLPOINT

WellPoint is one of the nation's largest publicly traded health care companies serving the needs of more than 9.7 million medical and more than 40 million specialty members. WellPoint serves its customers in California through Blue Cross of California,* in Georgia through Blue Cross and Blue Shield of Georgia and in other parts of the country through UNICARE.

WellPoint was formed in 1992 to operate Blue Cross of California's health insurance business. In 1996, WellPoint and Blue Cross of California merged into a single stockholder-owned company, WellPoint Health Networks Inc.* (NYSE: WLP). That same year, WellPoint acquired the Life and Health Benefits Management Division of Massachusetts Mutual Life Insurance Company.®I In 1997, WellPoint acquired the Group Benefits Operation of John Hancock Mutual Life Insurance Company.®II In 2000, WellPoint completed the acquisition of Rush Prudential Health Plans of Illinois and a mail order pharmacy fulfillment facility which now operates under the name of PrecisionRx. In March 2001, WellPoint acquired Blue Cross and Blue Shield of Georgia.

The WellPoint group of companies employs approximately 13,800 full-time associates.

www.wellpoint.com

STRATEGIC STATES:
CA, TX, GA, IL/IN/OH,
MID-ATLANTIC

* Independent Licensee of the Blue Cross and Blue Shield Association
®I Registered Mark of Massachusetts Mutual Life Insurance Company
®II Registered Mark of John Hancock Mutual Life Insurance Company

UNICARE

UNICARE is WellPoint's national brand dedicated to the delivery of quality health care plans and products since 1996. Serving 2.3 million medical members, UNICARE employs over 3,800 full time associates.

With a growing reputation for innovation, UNICARE is committed to establishing a relationship with its customers as a trusted partner. UNICARE's strategy is to offer a diversified mix of products that preserve member choice at competitive prices while focusing on the development of new hybrid plans which take advantage of the best characteristics of traditional managed care and innovative open access models.

www.unicare.com

BLUE CROSS OF CALIFORNIA

Blue Cross of California has been serving the health care needs of Californians since 1937. As the California operating subsidiary of WellPoint, Blue Cross of California, together with its branded affiliates, provides services to 5.6 million California members. Blue Cross of California employs more than 6,200 full time associates.

Offering a full continuum of product coverage options, Blue Cross of California provides customers with unparalleled choice and flexibility in meeting their health plan needs. These options are continually fine-tuned to enhance access to affordable, quality health care. With its strong track record for innovation, Blue Cross of California focuses on products and services designed to improve the health status of all Californians. Unique product offerings available in the individual, small group, large group, senior and Medi-Cal markets include a full range of medical and specialty products.

www.bluecrossca.com

BLUE CROSS AND BLUE SHIELD OF GEORGIA

Blue Cross and Blue Shield of Georgia is WellPoint's operating subsidiary in Georgia. Blue Cross and Blue Shield of Georgia employs 2,900 associates and is Georgia's largest and oldest health insurer, providing health benefits to more than 1.8 million Georgians.

Founded in 1937, Blue Cross and Blue Shield of Georgia is headquartered in Atlanta, with major operations centers in Atlanta and Columbus. Blue Cross and Blue Shield of Georgia offers significant value to its members by providing a wide range of products including traditional indemnity insurance, open-access plans and managed care products. Blue Cross and Blue Shield of Georgia also markets specialty products including life insurance, dental, vision, mental health and pharmacy.

www.bcbsga.com

FINANCIAL HIGHLIGHTS

(In thousands, except per-share data and membership)	*Year Ended December 31,*				
	2000	**1999**	**1998**	**1997**	**1996**
CONSOLIDATED OPERATING RESULTS [A]					
Revenues	$9,228,958	$7,485,427	$6,478,350	$5,642,238	$3,970,832
Income from continuing operations before extraordinary gain and cumulative effect of accounting change	342,287	297,211	319,548	229,437	198,518
Net income	342,287	278,544	231,280	227,409	202,002
Per-share data					
Income from continuing operations before extraordinary gain and cumulative effect of accounting change					
Earnings Per Share	$ 5.47	$ 4.50	$ 4.63[B]	$ 3.33[C]	$ 2.99
Earnings Per Share Assuming Full Dilution	$ 5.29	$ 4.38	$ 4.55[B]	$ 3.30[C]	$ 2.99
Net income					
Earnings Per Share	$ 5.47	$ 4.22	$ 3.35[B]	$ 3.30[C]	$ 3.04
Earnings Per Share Assuming Full Dilution	$ 5.29	$ 4.10	$ 3.29[B]	$ 3.27[C]	$ 3.04
CONSOLIDATED FINANCIAL POSITION [A]					
Total assets	$5,504,706	$4,593,234	$4,225,834	$4,234,124	$3,149,378
Total liabilities	3,860,289	3,280,534	2,910,611	3,010,955	2,278,919
Total stockholders' equity	1,644,417	1,312,700	1,315,223	1,223,169	870,459
MEMBERSHIP					
Medical	7,869,000	7,300,000	6,892,000	6,638,000	4,485,000
Pharmacy	29,039,000	21,980,000[D]	15,003,000	12,290,000	11,517,000
Dental	2,246,000	2,453,000	3,149,000	3,183,000	1,559,000
Utilization management	2,103,000	2,665,000	2,908,000	2,751,000	—
Life	2,020,000	2,125,000	2,156,000	1,758,000	723,000
Disability	569,000	598,000	779,000	1,126,000	107,000
Behavioral health	4,353,000[F]	2,157,000[E]	744,000	721,000	502,000

A. Financial information prior to 1998 has been restated to include the Company's workers' compensation business (which was sold in 1998) as a discontinued operation.

B. Per-share data for 1998 includes a charge of $0.42 per basic and diluted share related to the Company's investment in FPA Medical Management, Inc. and income of $1.24 per basic and $1.22 per diluted share related to the Company's favorable IRS ruling regarding the deductibility of a cash payment made by the Company's former parent company at the time of its May 1996 Recapitalization.

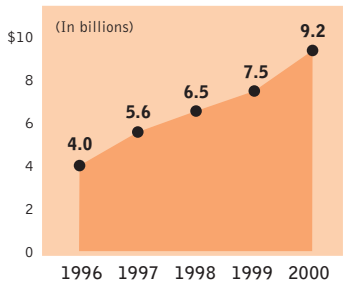
C. Per-share data includes nonrecurring costs of $0.13 per basic and diluted share for 1997.

D. Effective January 1, 1999, WellPoint revised its methodology of counting pharmacy members. As a result of this revision, pharmacy members for whom WellPoint provides claims processing services are now counted separately from pharmacy members for whom WellPoint provides clinical management services.

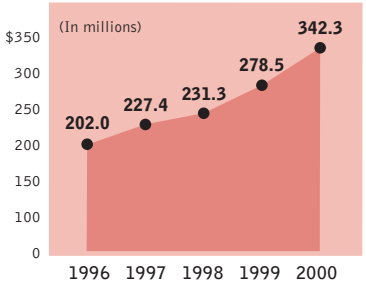
E. The increase in behavioral health membership is due to approximately 1.4 million additional California large employer group and certain state-sponsored program members whose behavioral health benefits were formerly not counted separately from medical benefits.

F. Behavioral health membership as of December 31, 2000 reflects an addition of approximately 1.6 million members over December 31, 1999 due to the mental health parity requirements in the State of California, which became effective in the third quarter of 2000.

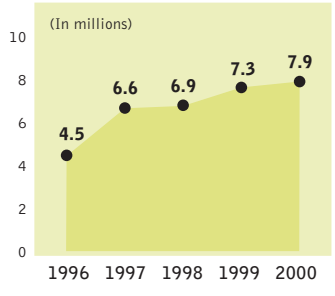
Revenues



Net Income



Medical Membership



Chairman's Letter

To Our Stockholders

We continued to meet the health care financing needs of our customers in 2000. This was demonstrated in part by the growth of our membership base — WellPoint added 569,000 new medical members during the year.

Our success in meeting customer needs generated excellent financial results. Our revenues grew 23 percent to $9.2 billion. The Company's diluted earnings per share grew by 21 percent over comparable results for 1999, excluding extraordinary gain and cumulative effect of accounting change. WellPoint's operating cash flow was $648 million, reflecting the underlying strength of our business.

Our continued financial stability gives our members a sense of security that we will be there to help finance the cost of health care services when they are needed. WellPoint's financial strength also benefits our stockholders. The Company's performance in 2000 led to an increase in our stock price of 75 percent. Since WellPoint's recapitalization in May 1996, our stock has appreciated 196 percent (a compounded annual rate of 27 percent), significantly outperforming our industry peer group.

MARCH 2001
WLP P/E ≈ 16
S+P 500 P/E ≈ 22

The appreciation of our stock price over this period also benefited the California HealthCare Foundation. The Foundation, which received 53.4 million shares of WellPoint stock as part of the 1996 conversion of Blue Cross of California to for-profit status, announced in January 2001 that it completed the monetization of its shares. Through four secondary offerings beginning in November 1996 and orderly sales in the open market during the fourth quarter of 2000, the Foundation generated net proceeds of over $3 billion. This successful monetization, together with nearly $800 million in cash transferred to a second Foundation as part of the conversion, will benefit Californians for many generations to come.

Building Our Business

We also took steps to expand our business outside California during 2000 by completing two acquisitions — Rush Prudential Health Plans and PrecisionRx. The Rush Prudential transaction added a strong physician and hospital network and new product offerings to our existing operations in the Illinois market, an area we have identified as a strategic focus. PrecisionRx completes our pharmacy benefits management capabilities with a pharmacy mail order facility in Fort Worth, Texas.

Our acquisition in March 2001 of Cerulean Companies, Inc., the parent of Blue Cross and Blue Shield of Georgia, offers outstanding potential in another area of focus, the Southeast. The Cerulean merger allows WellPoint to build on the success of Blue Cross and Blue Shield of Georgia by providing consumers with choice-based products that offer significant value. We expect to introduce innovative hybrid products that combine the best features of open-access and managed care plans. WellPoint also has opportunities to increase sales in the individual and small group market and to offer enhanced services to Georgia employers that have a national presence.

WellPoint also continues to challenge conventional wisdom. We are the first health plan to petition the Food and Drug Administration to move a drug from prescription to over-the-counter status. The drug is Claritin, an excellent pharmaceutical which is safer than current over-the-counter substitutes, but which can be purchased in Canada without a prescription for about $15 per standard dosage versus about $65 (not including the cost of a physician visit to get the prescription) in the U.S.

Many health plans appear to be reducing their support of an important distribution channel for products sold to individuals and small groups — agents and brokers. We look for ways to support them. Internet-enabling sales tools, stable commission schedules and enhanced training sessions reflect the support we offer agents and brokers at events like our "Sellebration" satellite sales tour.

Industrywide Issues

Last year we focused on the concerns that many Americans have about HMOs. Even though only 31 percent of WellPoint's members are in HMO plans, we recognize the need to take concrete steps to improve the health care experience for American consumers and medical professionals. The industry and WellPoint have made progress, but it is just the beginning.

Early in 2000, WellPoint and 23 of the nation's largest health plans joined in a cooperative effort called the Coalition for Affordable Quality Healthcare (CAQH). Companies in the coalition are focused on three areas:

- enabling consumers to have access to quality coverage and information;
- making administration easier for doctors and consumers; and
- working with doctors to help them improve overall health care quality.

Realizing that actions speak louder than words, the coalition is achieving concrete results. In February 2001, the coalition announced that all CAQH health plans would assure access to coverage for key services including OB/GYNs and pediatricians, emergency room stays and independent review of medical necessity decisions. The coalition also announced a partnership with the U.S. Centers for Disease Control and Prevention to address the growing public health threat of antibiotic resistance. We expect additional initiatives to follow over the next year.

WellPoint took action in 2000 to better serve customers and health care professionals. The Company continues to enhance its Internet-based product that allows physicians to reduce their administrative burden by accessing a patient's benefits, eligibility and claims information on-line. To help improve our relationships with physicians, Woodrow Myers, M.D., a nationally recognized leader in the development of medical quality initiatives and innovative health care management programs, joined us as chief medical officer from Ford Motor Company.

An Immediate Opportunity

Today, premiums for health insurance, driven by underlying medical costs, are generally rising at more than twice the overall inflation rate. We have the best medical system in the world, and yet it is increasingly unaffordable. The challenge for WellPoint and others in the industry is to mitigate increases in the cost of insurance while demonstrating more value added in products and services.

We are focused on three areas related to this challenge — innovative health plan design, quality improvement in collaboration with physicians and hospitals, and programs to help members effectively navigate the health care system for major needs.

Innovative Health Plan Designs

WellPoint has long provided significant choice for consumers in the design of its plans. At the end of 2000, 69 percent of our members had coverage in open-access products that offer considerable freedom in accessing care and managing out-of-pocket costs. One of the keys to our future growth is to keep premiums affordable by designing plans that give members more options.

WellPoint has led the movement away from the prepaid health care coverage of an HMO toward a more effective concept of insurance. Our philosophy with regard to plan design is to give consumers choices on tradeoffs between premiums and coverage levels for minor to moderate health care needs. At the same time, give consumers security in knowing that WellPoint will be there to finance and assist them with their major medical needs.

Anticipating that there will be increased demand in the future to reduce the rate of increase in premiums and make premiums more predictable, WellPoint is introducing new plan designs in its individual and small group market segments. In January 2001 we launched PlanScape for our California individual PPO members. This program offers a simple array of plan selections with cost sharing features geared toward preserving access to important medical coverage and services at a manageable cost. Members decide whether they prefer greater cost sharing at a lower premium or lower out-of-pocket costs for a higher premium.

In April 2001, WellPoint also expects to introduce FlexScape for small employers, the first defined contribution program of its kind. This program offers employers more predictability through fixed or customized premium contribution options and more choices for employees. We are well-positioned to lead this trend because of our thorough knowledge of the buying preferences of the individual and small group markets.

Quality Improvement

Despite significant advances in health care, the need for quality improvement in the practice of medicine is ongoing. In September 2000, a national publication reported that the frequency of certain surgeries varies widely across the nation depending on where a patient lives, not on recognized standards of care. A heart patient in one community was seven times more likely to undergo an artery-clearing procedure than a similar patient in a neighboring state.

We believe we can play an important role in encouraging the use of nationally recognized medical protocols and best practices. For major diseases and chronic conditions, our health care professionals routinely share standards of care from top academic institutions and leading specialty medical associations with members and doctors. These efforts help ensure that medical care is based on the most up-to-date clinical standards.

We also are working to optimize the quality of our networks with programs like Centers of Excellence. For major health care services, such as organ transplants, we work to identify and assess the best health care facilities based on quality factors such as survival rates, complications frequency, number of cases, and the experience of the medical team. A specialized network is created by collaborating with selected physicians and hospitals to direct members to the centers and communicate options to the patient. We believe these efforts can help achieve better medical outcomes, happier patients and lower costs.

Serving as a Medical Concierge

Recent studies have shown that consumers want more information regarding their health, more involvement in medical decision making, and help accessing the health care system. We have anticipated these trends and are working to provide consumer service that offers guidance and assistance. We view one of our roles as that of a medical concierge for medical needs and health information — helping our members obtain the treatment information they want and the most appropriate care they need.

WellPoint's health management programs for members with diabetes, asthma and other chronic conditions are examples of this effort. After a member has agreed to participate in a program, the severity of the disease and the member's willingness to change are evaluated. We then proactively employ a full-team approach by coordinating the member's care with the member's physician, pharmacist and other clinicians.

The health management program is designed to help improve medical outcomes, reduce condition-related complications, and enhance quality of life. Consider our diabetes program. After three years of participation, members on average have a significant reduction in emergency room visits and an increase in interaction with their primary care doctor — a positive outcome. Also, the longer a member participates in the program, the more the member's blood tests for diabetes have shown to approach normal levels.

Other examples of our efforts to provide real value to our members through medical assistance, quality initiatives and product design are described in this annual report.

Future Growth

The future offers significant opportunities for WellPoint. For example, medical technology continues to advance. That is good news for all of us. The issue is affordability — we will need to find creative ways to finance coverage for new medical breakthroughs.

Aging Baby Boomers also will provide growth potential for WellPoint. They want to look good, feel good, and live longer than their parents. And while Baby Boomers often have the financial means to consume a much larger amount of health care services than past generations, they will want to protect their assets. That's where our product innovation and financial stability can offer substantial value over a long-term customer relationship.

In addition, there likely will be further consolidation in our industry as some companies assess whether they can compete effectively over the long term. We will continue to look at opportunities as they arise to determine if our competencies can add significant value for our customers and stockholders.

WellPoint is positioned for growth in 2001 thanks to the hard work and quality of our associates, the excellence of our management team, and the leadership provided by our board of directors. All of us are stockholders of WellPoint and can participate in programs to increase our ownership. Together, we look forward to enhancing the value of our Company by securing a healthy future for our members.

Leonard D. Schaeffer
Chairman and Chief Executive Officer
March 2001

BOARD OF DIRECTORS

LEONARD D. SCHAEFFER *(standing far right)*
Chairman of the Board of Directors
and Chief Executive Officer,
WellPoint Health Networks Inc.

W. TOLIVER BESSON *(standing second from right)*
Chair of the Nominating
& Governance Committee and
Member of the Audit Committee
Partner, Paul, Hastings, Janofsky & Walker

SHEILA P. BURKE *(standing center)*
Member of the Audit Committee and
the Compensation Committee
Undersecretary for American Museums
& National Programs,
Smithsonian Institution

ELIZABETH A. SANDERS *(standing second from left)*
Member of the Compensation Committee and
the Nominating & Governance Committee
Principal, The Sanders Partnership

STEPHEN L. DAVENPORT *(standing far left)*
Member of the Compensation Committee
Former President, D/A Financial Group

JULIE A. HILL *(seated right)*
Chair of the Compensation Committee and
Member of the Nominating & Governance Committee
Owner, The Hill Companies

ROGER E. BIRK *(seated left)*
Chair of the Audit Committee
Former Chairman and Chief Executive Officer,
Merrill Lynch, Pierce, Fenner & Smith Incorporated

WARREN Y. JOBE *(not pictured)*
Senior Vice President
Southern Company

REPORT OF INDEPENDENT ACCOUNTANTS

TO THE STOCKHOLDERS AND BOARD OF DIRECTORS
WELLPOINT HEALTH NETWORKS INC.

We have audited, in accordance with auditing standards generally accepted in the United States of America, the consolidated financial statements of WellPoint Health Networks Inc. as of December 31, 2000 and 1999, and for each of the three years in the period ended December 31, 2000, appearing in the proxy statement for the 2001 annual meeting of stockholders of the corporation (which statements are not presented herein), and in our report dated January 31, 2001, except note 23 as to which the date is March 15, 2001, we expressed an unqualified opinion on those consolidated financial statements, which included an explanatory paragraph that effective January 1, 1999, the Company changed its method of accounting for start-up costs related to the Company's providers and sales network development costs. In our opinion, the information set forth in the accompanying condensed consolidated balance sheets as of December 31, 2000 and 1999, and the related condensed consolidated income statements and condensed consolidated statements of changes in stockholders' equity and cash flows for each of the three years in the period ended December 31, 2000, when read in conjunction with the consolidated financial statements from which it has been derived, is fairly stated in all material respects in relation thereto.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Los Angeles, California
January 31, 2001, except note 23 as to which the date is March 15, 2001

RESPONSIBILITY FOR FINANCIAL STATEMENTS

TO THE STOCKHOLDERS OF WELLPOINT HEALTH NETWORKS INC.

The Company's management is responsible for the integrity and objectivity of the financial information contained in this annual report.

Management maintains and is responsible for systems of internal accounting controls to provide reasonable assurance of the integrity and reliability of the financial statements, safeguarding of assets and that transactions are executed in accordance with management's authorization and are accurately reflected in the books and records of the Company. The Company maintains an extensive internal auditing program that independently assesses the effectiveness of these internal controls with written reports and recommendations issued to the appropriate levels of management. Management believes that the existing systems of internal controls are achieving the objectives discussed herein.

WellPoint's Audit Committee of the Board of Directors is responsible for reviewing the Company's financial reporting, accounting and internal control practices and recommending the selection of independent auditors. The Company's internal and independent auditors have full and free access to the Audit Committee and meet with it to discuss all appropriate matters.

Kenneth C. Zurek

Kenneth C. Zurek
Senior Vice President,
Controller & Taxation
WellPoint Health Networks Inc.
January 31, 2001

CONDENSED CONSOLIDATED BALANCE SHEETS

(In thousands, except share data)	*December 31,*	
	2000	**1999**
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 566,889	$ 505,014
Investment securities, at market value	3,096,350	2,645,372
Receivables, net	699,868	513,079
Deferred tax assets	77,757	92,774
Other current assets	59,545	59,725
Total Current Assets	4,500,409	3,815,964
Property and equipment, net	151,031	125,917
Intangible assets, net	165,164	96,298
Goodwill, net	418,120	307,647
Long-term investments, at market value	116,811	108,280
Deferred tax assets	92,982	84,063
Other non-current assets	60,189	55,065
Total Assets	$5,504,706	$4,593,234
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES:		
Medical claims payable	$1,566,569	$1,142,183
Reserves for future policy benefits	58,085	57,435
Unearned premiums	232,132	230,407
Accounts payable and accrued expenses	513,637	440,412
Experience rated and other refunds	249,725	223,066
Income taxes payable	53,898	84,026
Other current liabilities	398,867	349,757
Total Current Liabilities	3,072,913	2,527,286
Accrued postretirement benefits	71,510	68,903
Reserves for future policy benefits, non-current	267,552	291,626
Long-term debt	400,855	347,884
Other non-current liabilities	47,459	44,835
Total Liabilities	3,860,289	3,280,534
STOCKHOLDERS' EQUITY:		
Preferred Stock – $0.01 par value, 50,000,000 shares authorized, none issued and outstanding	—	—
Common Stock – $0.01 par value, 300,000,000 shares authorized, 71,390,971 issued at December 31, 2000 and 1999	714	714
Treasury stock, at cost, 8,566,399 and 7,764,668 shares at December 31, 2000 and 1999, respectively	(536,524)	(481,331)
Additional paid-in capital	983,028	955,016
Retained earnings	1,145,464	854,642
Accumulated other comprehensive income	51,735	(16,341)
Total Stockholders' Equity	1,644,417	1,312,700
Total Liabilities and Stockholders' Equity	$5,504,706	$4,593,234

CONDENSED CONSOLIDATED INCOME STATEMENTS

(In thousands, except earnings per share)	*Year Ended December 31,*		
	2000	**1999**	**1998**
Revenues:			
Premium revenue	$8,583,663	$6,896,857	$5,934,812
Management services revenue	451,847	429,336	433,960
Investment income	193,448	159,234	109,578
	9,228,958	7,485,427	6,478,350
Operating Expenses:			
Health care services and other benefits	6,935,398	5,533,068	4,776,345
Selling expense	394,217	328,619	280,078
General and administrative expense	1,265,155	1,075,449	975,099
	8,594,770	6,937,136	6,031,522
Operating Income	634,188	548,291	446,828
Interest expense	23,978	20,178	26,903
Other expense, net	45,897	40,792	27,939
Income from Continuing Operations before Provision for Income Taxes, Extraordinary Gain and Cumulative Effect of Accounting Change	564,313	487,321	391,986
Provision for income taxes	222,026	190,110	72,438
Income from Continuing Operations before Extraordinary Gain and Cumulative Effect of Accounting Change	342,287	297,211	319,548
Discontinued Operations:			
Loss from Workers' Compensation Segment, net of tax benefit of $6,959	—	—	(12,592)
Loss on disposal of Workers' Compensation Segment, net of tax benefit of $33,022	—	—	(75,676)
Loss from Discontinued Operations	—	—	(88,268)
Extraordinary Gain from Early Extinguishment of Debt, net of tax	—	1,891	—
Cumulative Effect of Accounting Change, net of tax	—	(20,558)	—
Net Income	$ 342,287	$ 278,544	$ 231,280
Earnings Per Share:			
Income from continuing operations before extraordinary gain and cumulative effect of accounting change	$ 5.47	$ 4.50	$ 4.63
Loss from discontinued operations	—	—	(1.28)
Extraordinary gain from early extinguishment of debt, net of tax	—	0.03	—
Cumulative effect of accounting change, net of tax	—	(0.31)	—
Net income	$ 5.47	$ 4.22	$ 3.35
Earnings Per Share Assuming Full Dilution:			
Income from continuing operations before extraordinary gain and cumulative effect of accounting change	$ 5.29	$ 4.38	$ 4.55
Loss from discontinued operations	—	—	(1.26)
Extraordinary gain from early extinguishment of debt, net of tax	—	0.02	—
Cumulative effect of accounting change, net of tax	—	(0.30)	—
Net income	$ 5.29	$ 4.10	$ 3.29

CONDENSED CONSOLIDATED STATEMENTS OF CHANGES IN STOCKHOLDERS' EQUITY

(In thousands)

		Common Stock			
	Preferred	Issued		In Treasury	
	Stock	Shares	Amount	Shares	Amount
BALANCE AS OF JANUARY 1, 1998	$ —	69,778	$698	5	$ (103)
Stock grants to employees and directors		6			
Stock issued for employee stock option and stock purchase plans		837	8		
Stock repurchased, at cost				3,497	(193,332)
Comprehensive income					
Net income					
Other comprehensive income, net of tax					
Change in unrealized valuation adjustment on investment securities, net of reclassification adjustment					
Total comprehensive income					
BALANCE AS OF DECEMBER 31, 1998	—	70,621	706	3,502	(193,435)
Stock grants to employees and directors		75	1	(4)	172
Stock issued for employee stock option and stock purchase plans		695	7	(66)	3,616
Stock repurchased, at cost				4,333	(291,684)
Net losses from treasury stock reissued					
Comprehensive income					
Net income					
Other comprehensive income, net of tax					
Change in unrealized valuation adjustment on investment securities, net of reclassification adjustment					
Foreign currency adjustments, net of tax					
Total comprehensive income					
BALANCE AS OF DECEMBER 31, 1999	—	71,391	714	7,765	(481,331)
Stock grants to employees and directors				(15)	1,013
Stock issued for employee stock option and stock purchase plans				(1,668)	118,396
Stock repurchased, at cost				2,484	(174,602)
Net losses from treasury stock reissued					
Comprehensive income					
Net income					
Other comprehensive income, net of tax					
Change in unrealized valuation adjustment on investment securities, net of reclassification adjustment					
Foreign currency adjustments, net of tax					
Total comprehensive income					
BALANCE AS OF DECEMBER 31, 2000	$ —	71,391	$714	8,566	$(536,524)

Additional Paid - in Capital	*Retained Earnings*	*Accumulated Other Comprehensive Income*	*Total*
$882,312	$ 345,318	$ (5,056)	$1,223,169
399			399
39,036			39,044
			(193,332)
	231,280		231,280
		14,663	14,663
	231,280	14,663	245,943
921,747	576,598	9,607	1,315,223
3,051			3,224
30,218			33,841
			(291,684)
	(500)		(500)
	278,544		278,544
		(26,179)	(26,179)
		231	231
	278,544	(25,948)	252,596
955,016	854,642	(16,341)	1,312,700
			1,013
28,012			146,408
			(174,602)
	(51,465)		(51,465)
	342,287		342,287
		68,045	68,045
		31	31
	342,287	68,076	410,363
$983,028	$1,145,464	$51,735	$1,644,417

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

(In thousands)	*Year Ended December 31,*		
	2000	**1999**	**1998**
CASH FLOWS FROM OPERATING ACTIVITIES:			
Income from continuing operations before extraordinary gain and cumulative effect of accounting change	$ 342,287	$ 297,211	$ 319,548
Adjustments to reconcile income from continuing operations before extraordinary gain and cumulative effect of accounting change to net cash provided by continuing operating activities:			
Depreciation and amortization, net of accretion	75,402	68,767	54,590
Loss on sales of assets, net	24,170	31,898	34,679
Provision (benefit) for deferred income taxes	(61,188)	41,087	(83,261)
Amortization of deferred gain on sale of building	(4,426)	(4,426)	(4,425)
Accretion of interest on zero coupon convertible subordinated debentures	2,971	1,465	—
(Increase) decrease in certain assets:			
Receivables, net	(162,375)	(29,263)	17,621
Income taxes recoverable	—	191,079	15,099
Other current assets	1,829	(26,169)	(20,087)
Other non-current assets	(5,324)	(8,451)	1,978
Increase (decrease) in certain liabilities:			
Medical claims payable	367,189	195,681	23,844
Reserves for future policy benefits	(23,424)	(25,019)	(9,142)
Unearned premiums	1,460	15,349	18,853
Accounts payable and accrued expenses	61,856	107,086	(6,415)
Experience rated and other refunds	26,659	(26,619)	(5,810)
Income taxes payable	(30,070)	—	—
Other current liabilities	20,692	(5,227)	35,398
Accrued postretirement benefits	2,607	1,845	3,167
Other non-current liabilities	7,634	3,064	(1,027)
Net cash provided by continuing operating activities	647,949	829,358	394,610
Loss from discontinued operations	—	—	(12,592)
Adjustment to derive cash flows from discontinued operating activities			
Change in net operating assets	—	—	7,410
Net cash used in discontinued operating activities	—	—	(5,182)
Net cash provided by operating activities	647,949	829,358	389,428
CASH FLOWS FROM INVESTING ACTIVITIES:			
Investments purchased	(3,427,465)	(3,456,317)	(2,843,102)
Proceeds from investments sold	2,979,906	2,892,802	2,666,355
Proceeds from investments matured	86,412	83,404	106,436
Property and equipment purchased	(46,891)	(38,516)	(78,431)
Proceeds from property and equipment sold	2,358	1,925	25,721
Proceeds from sale of Workers' Compensation business	—	—	101,413
Settlement of sales price for sale of Workers' Compensation business	—	(6,733)	—
Acquisition of new businesses, net of cash acquired	(151,748)	(7,700)	—
Net cash used in continuing investing activities	(557,428)	(531,135)	(21,608)
Net cash provided by investing activities of discontinued operations	—	—	15,877
Net cash used in investing activities	(557,428)	(531,135)	(5,731)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Proceeds from issuance of zero coupon convertible subordinated debentures	—	200,823	—
Net borrowing (repayment) of long-term debt under the revolving credit facility	50,000	(149,788)	(88,000)
Proceeds from issuance of common stock	95,956	36,565	39,443
Common stock repurchased	(174,602)	(291,684)	(193,332)
Net cash used in financing activities	(28,646)	(204,084)	(241,889)
Net increase in cash and cash equivalents	61,875	94,139	141,808
Cash and cash equivalents at beginning of period	505,014	410,875	269,067
Cash and cash equivalents at end of period	$ 566,889	$ 505,014	$ 410,875

EXECUTIVE OFFICERS

LEONARD D. SCHAEFFER
Chairman and Chief Executive Officer

DAVID S. HELWIG
Executive Vice President
Large Group Division

JOAN E. HERMAN
Executive Vice President
Senior, Specialty and State Sponsored Programs Divisions

REBECCA A. KAPUSTAY
Executive Vice President
Blue Cross and Blue Shield of Georgia

D. MARK WEINBERG
Executive Vice President
Individual and Small Group Division

DAVID C. COLBY
Executive Vice President
Chief Financial Officer

THOMAS C. GEISER
Executive Vice President
General Counsel & Secretary

WOODROW A. MYERS, JR., M.D.
Executive Vice President
Chief Medical Officer

DIRECTORS

W. TOLIVER BESSON
Partner
Paul, Hastings, Janofsky & Walker

ROGER E. BIRK
Former Chairman and
Chief Executive Officer
Merrill Lynch, Pierce,
Fenner & Smith Incorporated

SHEILA P. BURKE
Undersecretary for American
Museums & National Programs
Smithsonian Institution

STEPHEN L. DAVENPORT
Former President
D/A Financial Group

JULIE A. HILL
Owner
The Hill Companies

WARREN Y. JOBE
Senior Vice President
Southern Company

ELIZABETH A. SANDERS
Principal
The Sanders Partnership

LEONARD D. SCHAEFFER
Chairman and Chief Executive Officer
WellPoint Health Networks Inc.

CORPORATE DATA

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Los Angeles, CA 90071

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(800) 356-2017

INVESTOR CONTACT
John Cygul
Vice President
Investor and Corporate Communications
(805) 557-6789

FORM 10-K REPORT
Stockholders may receive without charge a copy of the WellPoint Health Networks Inc. Annual Report on Form 10-K as filed with the Securities and Exchange Commission by contacting Investor Relations at the Company's corporate headquarters.

STOCK LISTING
Common Stock of WellPoint Health Networks Inc. trades on the New York Stock Exchange under the symbol WLP.

Condensed consolidated financial statements are included in the annual report. The complete consolidated financial statements and related notes have been mailed to all stockholders with the proxy materials related to the 2001 Annual Meeting of Stockholders to be held May 8, 2001. A copy of WellPoint's Annual Report on Form 10-K filed with the Securities and Exchange Commission may be obtained free of charge from Investor Relations at WellPoint's corporate headquarters.

Cautionary Statement: Certain statements contained in this Annual Report are forward-looking statements. Actual results could differ materially due to, among other things, operational and other difficulties associated with integrating acquired businesses, rising health care costs and trends affecting medical loss ratios, health care reform and other regulatory issues, difficulties in obtaining regulatory approvals of pending transactions, competition among managed care companies and general business conditions. Additional risk factors are listed from time to time in the Company's various reports filed with the Securities and Exchange Commission, including the Company's Annual Report on Form 10-K for the year ended December 31, 2000.

WellPoint Health Networks Inc., Blue Cross of California and Blue Cross and Blue Shield of Georgia are Independent Licensees of the Blue Cross and Blue Shield Association.

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Design: Baker Designed Communications
Illustration: Bill Brown, Sharon Dodge + Associates
Content: WellPoint Investor and Corporate Communications

VISION

WellPoint will redefine our industry through a new generation of consumer-friendly products that put individuals back in control of their health and financial future.

MISSION

The WellPoint companies provide health security by offering a choice of quality branded health and related financial services designed to meet the changing expectations of individuals, families and their sponsors throughout a lifelong relationship.

1 WELLPOINT WAY
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